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Gateway Health
Prior Authorization Criteria
Opioid Analgesics

All requests for Opioid Analgesics require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Opioid Analgesics Prior Authorization Criteria:

Requests for opioid analgesics may be subject to prior authorization and will be screened for medical necessity and appropriateness using the prior authorization criteria listed below.

All requests for opioids will reject for members with an active claim for opioid dependence treatment (e.g. buprenorphine/naloxone, naltrexone) and will be subject to individual review and approval. In addition to the criteria outlined in sections I, II, and III, the reviewer will consider whether:

- Both of the prescriptions are written by the same prescriber or, if written by different prescribers, all prescribers are aware of the other prescription(s)
- The beneficiary has a need for therapy with an opioid and buprenorphine therapy will be suspended during the treatment for pain.

Members with documented active cancer, hospice/palliative care, or sickle cell diagnoses are exempt from prior authorization requirements.

Section I. Short-acting opioid Prior Authorization Criteria

- Coverage may be provided for a **short-acting opioid** when the duration of therapy threshold is exceeded and the following criteria is met:
  - Duration of therapy thresholds:
    - Prior authorization is required for adults (≥ 21 years of age) when more than a 5 day supply is prescribed (whether obtained from a single prescription or multiple prescriptions) in a 30 day period.
    - Prior authorization is required for children (< 21 years of age) when more than a 3 day supply is prescribed (whether obtained from a single prescription or multiple prescriptions) in a 30 day period.

Initial Criteria

i. A pain assessment (type, cause, duration, severity of pain, etc.) is provided.
ii. Documentation of anticipated duration of therapy
iii. Documentation the member has tried and failed or has an intolerance or contraindication to non-pharmacologic therapies (e.g. behavioral, cognitive, physical therapies, and in situations where covered, acupuncture and/or yoga).

iv. Documentation the member has tried and failed or has an intolerance or contraindication to non-opioid analgesics (e.g. acetaminophen, NSAID, antidepressant, anticonvulsant).
v. Documentation the short-acting opioid will be used in combination with tolerated non-pharmacologic therapy and non-opioid pharmacologic therapy.
vi. The prescribing provider, or the prescribing provider's delegate, confirms they have reviewed the Pennsylvania Prescription Drug Monitoring Program (PDMP) database for the member's controlled substance prescription history.
i. Provider has evaluated the member for risk factors for opioid-related harm.
    1. If the member is identified at high risk for opioid related harm, the provider has educated the member on being a candidate for carrying naloxone.
vii. Documentation the member, or parent/guardian, has been educated on the potential adverse effects of opioid analgesics, including the risk of misuse, abuse, and addiction.
viii. Member is not taking a benzodiazepine, unless the benzodiazepine or opioid is being tapered or concomitant use is determined medically necessary.
ix. A recent UDS has been completed and results are consistent with prescribed controlled substances. If the UDS is not consistent, provider must state the results and resolution.
x. Authorization length: up to three (3) months

Reauthorization criteria

i. Documentation is submitted that shows an improvement in pain control and level of functioning. Rationale is provided for continued use of opioid therapy or a plan for taper/discontinuation.
ii. Documentation the short-acting opioid will be used in combination with tolerated non-pharmacologic therapy and non-opioid pharmacologic therapy.
iii. The prescribing provider, or the prescribing provider's delegate, confirms they have reviewed the Pennsylvania Prescription Drug Monitoring Program (PDMP) database for the member's controlled substance prescription history.
iv. Provider has evaluated the member for risk factors for opioid-related harm.
    1. If the member is identified at high risk for opioid related harm, the provider has educated the member on being a candidate for carrying naloxone.
v. Member is being monitored by the prescriber for adverse events and warning signs for serious problems, such as overdose and opioid use disorder.
vi. Member is not taking a benzodiazepine, unless the benzodiazepine or opioid is being tapered or concomitant use is determined medically necessary.
vii. A UDS has been completed every 6 months and results are consistent with prescribed controlled substances. If the UDS is not consistent, provider must state the results and resolution.
viii. Authorization length: up to six (6) months
    1. In situations when the request is deemed not medically necessary and the member is currently on chronic opioids and/or benzodiazepines, up to a three (3) month authorization will be granted to allow for tapering of medication(s).

2. For members who require longer than a 3 month taper, the provider must submit either a tapering plan or discontinuation plan to support the extended length of time.

Section II. Long-acting opioid Prior Authorization Criteria

All long-acting opioids require prior authorization and will be screened for medical necessity and appropriateness using the prior authorization criteria listed below.

- Coverage may be provided for a **long-acting opioid** when the following criteria is met:

Initial Criteria

i. A pain assessment (type, cause, duration, severity of pain, etc.) is provided.
ii. Documentation of anticipated duration of therapy
iii. Documentation the member has tried and failed or has an intolerance or contraindication to non-pharmacologic therapies (e.g. behavioral, cognitive, physical therapies, and in situations where covered, acupuncture and/or yoga).
iv. Documentation the member has tried and failed or has an intolerance or contraindication to non-opioid analgesics (e.g. acetaminophen, NSAID, antidepressant, anticonvulsant).
v. Documentation the long-acting opioid will be used in combination with tolerated non-pharmacologic therapy and non-opioid pharmacologic therapy.
vi. Documentation the member has had a trial of at least one short-acting opioid.
vii. The long-acting opioid must be prescribed for ongoing continuous therapy. Long-acting opioids are not intended to be used on an as-needed (prn) basis.
viii. The prescribing provider, or the prescribing provider's delegate, confirms they have reviewed the Pennsylvania Prescription Drug Monitoring Program (PDMP) database for the member's controlled substance prescription history.
ix. Provider has evaluated the member for risk factors for opioid-related harm.
    1. If the member is identified at high risk for opioid related harm, the provider has educated the member on being a candidate for carrying naloxone.
x. Documentation the member, or parent/guardian, has been educated on the potential adverse effects of opioid analgesics, including the risk of misuse, abuse, and addiction.
xi. Member is not taking a benzodiazepine, unless the benzodiazepine or opioid is being tapered or concomitant use is determined medically necessary.
xii. A recent UDS has been completed and results are consistent with prescribed controlled substances. If the UDS is not consistent, provider must state the results and resolution.
xiii. Authorization length: up to three (3) months

Reauthorization criteria

i. Documentation is submitted that shows an improvement in pain control and level of functioning. Rationale is provided for continued use of opioid therapy or a plan for taper/discontinuation.

ii. Documentation the long-acting opioid will be used in combination with tolerated non-pharmacologic therapy and non-opioid pharmacologic therapy.
iii. The prescribing provider, or the prescribing provider's delegate, confirms they have reviewed the Pennsylvania Prescription Drug Monitoring Program (PDMP) database for the member's controlled substance prescription history.
iv. Provider has evaluated the member for risk factors for opioid-related harm.
    1. If the member is identified at high risk for opioid related harm, the provider has educated the member on being a candidate for carrying naloxone.
v. Member is being monitored by the prescriber for adverse events and warning signs for serious problems, such as overdose and opioid use disorder.
vi. Member is not taking a benzodiazepine, unless the benzodiazepine or opioid is being tapered or concomitant use is determined medically necessary.
vii. A UDS has been completed every 6 months and results are consistent with prescribed controlled substances. If the UDS is not consistent, provider must state the results and resolution.
viii. Authorization length: up to six (6) months
    1. In situations when the request is deemed not medically necessary and the member is currently on chronic opioids and/or benzodiazepines, up to a three (3) month authorization will be granted to allow for tapering of medication(s).
    2. For members who require longer than a 3 month taper, the provider must submit either a tapering plan or discontinuation plan to support the extended length of time.

Section III. Quantity Limit Prior Authorization Criteria

Short and/or long-acting opioid analgesics will require prior authorization when exceeding a quantity limit and/or meeting or exceeding the cumulative daily dose threshold of 50 MME and will be screened for medical necessity and appropriateness using the prior authorization criteria listed below.

- Coverage may be provided for quantities exceeding the threshold or quantity limit when the following criteria is met (in addition to the above prior authorization criteria, if applicable):
    i. The prescribing provider, or the prescribing provider's delegate, confirms they have reviewed the Pennsylvania Prescription Drug Monitoring Program (PDMP) database for the member's controlled substance prescription history.
    ii. A treatment plan, including anticipated duration of therapy and clinical rationale to support medical necessity for the high dose, is provided.
    iii. For chronic pain diagnoses: If requesting high doses of short-acting opioids in the absence of a long-acting opioid, clinical rationale is provided for not utilizing a long-acting opioid.
    iv. For members meeting or exceeding 90 MME/day, the provider has educated the member on being a candidate for carrying naloxone.
    v. If requested dosing frequency exceeds the maximum FDA-approved dosing frequency, clinical rationale is provided to support medical necessity.
    vi. Authorization length: up to six (6) months

1. In situations when the request is deemed not medically necessary and the member is currently on chronic opioids and/or benzodiazepines, up to a three (3) month authorization will be granted to allow for tapering of medication(s).
2. For members who require longer than a 3 month taper, the provider must submit either a tapering plan or discontinuation plan to support the extended length of time.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary

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OPIOID ANALGESICS
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health[SM] Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Patient Name:	
Gateway ID:	DOB:

DRUG INFORMATION

Medication:	Strength & Frequency:
Quantity:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

BILLING INFORMATION

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

PLACE OF SERVICE INFORMATION

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis/diagnoses (include ICD 10 Code):

What is the suspected cause of pain (e.g. post-operative, neuropathic)?:

Is documentation of ongoing use of nonpharmacologic/nonopioid adjuctive therapy provided? ☐ Yes ☐ No

Is a pain assessment including the use of a pain assessment tool completed by the prescriber and attached?
☐ Yes ☐ No

Has the member or parent/guardian been educated on the potential adverse effects of opioid analgesics? ☐ Yes ☐ No

Has the patient been evaluated for risk factors for opioid-related harm? ☐ Yes ☐ No

If the patient is at high risk for opioid related harm, has the member been educated on being a candidate for carrying naloxone? ☐ Yes ☐ No

Has the provider reviewed the patient's Prescription Drug Monitoring Program (PDMP) profile? ☐ Yes ☐ No

- If **no**, please explain: _____

Is the patient currently taking a benzodiazepine? ☐ Yes, provide diagnosis: _____ ☐ No

- If **yes**, will there be an attempt to taper off benzodiazepine therapy? ☐ Yes ☐ No
  - If **no**, please provide clinical rationale for continuation while on opioid therapy:_____

The provider attests they are aware of the black box warning associated with concurrent use of benzodiazepines and opioids? ☐ Yes ☐ No

Has a urine drug screen been completed within the previous six months? ☐ Yes ☐ No

- Were the results consistent with current treatment and devoid of illicit substances? ☐ Yes ☐ No
- If **no**, please provide treatment plan and rationale for continuation of opioid therapy: _____

_____

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OPIOID ANALGESICS
PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

PREVIOUS MEDICATIONS AND/OR THERAPIES TRIED

Has the member tried and failed either of the following? **If yes**, please provide more information below.
☐ Non-pharmacologic therapies (e.g., behavioral, cognitive, physical and/or supportive therapies)
☐ Medications (e.g., acetaminophen, NSAIDS, antidepressants, anticonvulsants)

Medication/Therapy Name	Dose/ Frequency	Dates Tried	Reason therapy failed, discontinued, or contraindicated

OPIOID TAPER PLAN

If taping the member's opioids, please detail the plan below including the intended duration:

ADDITIONAL SUPPORTING INFORMATION or CLINICAL RATIONALE

REAUTHORIZATION CRITERIA

- Is an updated pain assessment provided? ☐ Yes ☐ No
- Has the patient had an improvement in pain and function? ☐ Yes ☐ No
- If **no**, please provide a treatment plan and rational for continued use:_____

_____

Prescribing Provider Signature	Date